**Screening for Domestic Violence in the Community Pediatric Setting**

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# Screening for Domestic Violence in the Community Pediatric Setting

Robert M. Siegel, MD*‡; Teresa D. Hill, PhD§; Vicki A. Henderson, MSW*; Heather M. Ernst, MSW*; and Barbara W. Boat, PhD‖

**ABSTRACT.** *Objective.* **Children exposed to domestic violence (DV) can experience a variety of adverse effects such as behavior disorders, developmental delay, and child abuse. Recently, the American Academy of Pediatrics recommended that all pediatricians incorporate screening for DV as a part of anticipatory guidance. To date, however, there is little information on how likely women are to disclose DV or whether there are any benefits to screening in the pediatric office setting. The purpose of our pilot study was to gain an understanding of whether screening for DV in the pediatric office setting could be helpful to abused women and their children.**

*Methods.* **During a 3-month period, 92% of the women who accompanied their children for a well-child visit to a hospital-based suburban pediatrician were asked about violence in the home with a six-question screening tool.**

*Results.* **Of the 154 women screened, 47 (31%) revealed DV at some time in their lives. Twenty-five women (17%) reported DV within the past 2 years and were reported to the mandated state agency. There were 5 episodes of child abuse reported of which two had not been previously reported. Interestingly, there were 5 women injured during their most recent pregnancy and who had separated from their abusive partner, but no legal action had been taken to protect them from their partner's return. There was no significant difference in the incidence of DV reported in families with Medicaid (37%) versus private insurance (20%). Before routine DV screening in our office, only one previous DV report had been made in 4 years.**

*Conclusions.* **Our preliminary results suggest that many women will reveal DV when screened in the pediatric office setting. Also, there is a subgroup of women, those with young children who have recently separated from their partners, who may particularly benefit from DV screening.** ***Pediatrics*** **1999;104:874–877;** ***domestic violence, child abuse, screening.***

ABBREVIATIONS. DV, domestic violence; AAP, American Academy of Pediatrics; KDVT, Kentucky Domestic Violence Team.

From the *Northern Kentucky Children's Advocacy Center, the St Luke Hospitals, Bellevue, Kentucky; the ‡Cincinnati Pediatric Research Group, Division of Community and General Pediatrics, Children's Hospital Medical Center, Cincinnati, Ohio; the §Catholic Health Initiatives, Louisville, Kentucky; and the ‖Division of Child Psychiatry, Children's Hospital Medical Center, Cincinnati, Ohio.

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Reprint requests to (R.M.S.) Northern Kentucky Children's Advocacy Center, 103 Landmark Dr, Bellevue, KY 41073. E-mail: robertsiegel56@pol.net



Domestic violence (DV) is a major health concern with as many as 10% to 40% of women disclosing abuse by their partners when screened by physicians in primary care settings.[1–5] The effects of DV often extend beyond the abused women. Children of abused women can experience a variety of adverse effects such as behavior disorders, developmental delay, and depression.[6–8] These children are also at risk for being abused themselves.[9] Recognizing these profound effects of DV on children, the American Academy of Pediatrics (AAP) recently recommended that all pediatricians incorporate screening for DV as a part of anticipatory guidance.[10]

Although DV screening by pediatricians could offer enormous benefit to children, barriers described by other specialists such as lack of time, inadequate training in how to screen, and fear of opening a Pandora's box make practitioners hesitant to screen.[11–13] Also, there are no studies describing the experience of DV screening in a community or private pediatric practice setting. Finally, there is little information on whether screening in any practice situation is ultimately of benefit to women or their children. Demonstrating the practicality of screening in the pediatric office could make acceptance of the AAP's recommendation more likely. The purpose of our pilot study was to describe the experience of screening for DV in a community pediatric setting.

## METHODS

During a 3-month period, all female guardians who accompanied their children for a pediatric well-child visit with the principle investigator were eligible for screening. The same pediatrician screened all women at one of two offices of a suburban pediatric practice. The practice, which is affiliated with a community hospital in northern Kentucky, cares for a population that is ~55% Medicaid, 36% private insurance, and 9% self-pay. Women were excluded from screening if their partner accompanied them to the pediatric visit.

The women were asked the following questions that were selected from recommended DV screening questions of the American Medical Association[1]:

1. Are you in a relationship now or have you ever been in a relationship in which you have been harmed or felt afraid of your partner?
2. Has your partner ever hurt any of your children?
3. Are you afraid of your current partner?

The following questions were also asked because of the links between DV and violence against pets and the presence of firearms in the household[14]:

4. Do you have any pets in the house?
5. Has your partner or child ever threatened or hurt any of the pets?

6. Are there any guns in your house?

If a woman's response was positive to any of the questions 1, 2, or 3 the case was referred to the practice's in-house social worker. All women who disclosed DV within the 2 years were referred to the Kentucky Domestic Violence Team (KDVT) in compliance with the mandated DV reporting required by the state of Kentucky. Kentucky law requires any means of infliction of physical pain, injury, or mental injury be reported (Kentucky Adult Protection Act, KRS 209). The KDVT suggests episodes that have occurred within 24 months be reported. All episodes of potential child abuse as reported historically with a response to question 2 were reported to the state child protective agency. After the interview with our social worker, referrals were made when deemed appropriate to a local women's center, legal services, and/or family counseling. For the purposes of the study, an acute event of DV was any event that occurred within the past 24 months. This was selected to be consistent with the state's requirement for reporting recent events of DV. Women were told of the need for reporting after disclosure of abuse by their partner or child abuse. The study was approved by the Children's Hospital Medical Center Institutional Review Board.

Logistic regression analysis was used to describe the differences in responses reported among the two sites as well as the differences between women of differing age groups, insurance status, and number of children.

## RESULTS

During a 3-month period, 154 women were screened. Throughout this period, 167 children were seen for well-child visits by the investigator giving a compliance of 92% for screening. The women ranged in age from 13 to 44 years old with an average age of 25.3 years. Sixty-five percent had Medicaid, 34% had private insurance, and 1% were self-pay. Ninety-eight percent of the women were white and 2% were black. The children who presented with the women ranged in age from 0 to 18 years with an average age of 1.9 years.

Table 1 summarizes the incidence of DV reported by the study group. A total of 47 women (31%) disclosed a history of injury by a partner at some point in their lives. Twenty-five women (16%) revealed abuse by their partner within the past 2 years. Ten of these 25 women were assaulted during their most recent pregnancy. There was no significant difference with regards to insurance status between the incidence of DV in mothers on Medicaid (37%) versus mothers with private insurance (20%). Although there was not a significant difference in acute abuse between those with private insurance and Medicaid (21% vs 8%), the difference would be significant if these percentages remained for a sample of 262 patients ($\alpha = 0.05$, $1\text{-}\beta = 0.8$).

A total of 90 study families owned pets, but only 2 women reported intentional injury to the pets. Both women, however, were abused at one time themselves with 1 reporting an old injury and 1 reporting an acute injury. Firearms were present in 24 (16%) of the study households with an incidence of DV of 25% in this group.

**TABLE 1.** The Incidence of Domestic Violence Reported by Insurance Status

| Type of Abuse | Insurance Status | | | *P* Value (Private Versus Medicaid) |
|---|---|---|---|---|
| | Private Insurance ($n = 51$) | Medicaid ($n = 99$) | Total ($n = 154$) | |
| Recent abuse | 4 (8%) | 21 (21%) | 24 (16%) | NS* |
| Past abuse | 6 (12%) | 16 (16%) | 23 (15%) | NS* |
| Total abuse | 10 (20%) | 37 (37%) | 47 (31%) | NS* |

* NS indicates not significant ($P > .05$).

The abusive scenarios of women who were abused within the past 24 months from the time of their screening are summarized in Table 2. Eight of the events occurred within 6 months of screening. Cases 1 through 10 were abused during their most recent pregnancy. A total of 7 women reported that they were currently afraid of their abusive partner. Of note, 5 of this subgroup were injured during their most recent pregnancy. In all, 7 of the 25 recent episodes (29%) had not been previously reported to the police or to the KDVT. Also, 4 of 5 episodes of child injury or threats disclosed by mothers occurred in families in which the mother reported fearing her partner. All 5 episodes of child abuse occurred in women who reported recent abuse by their partner and 2 of the episodes had not been reported before DV screening. Logistic regression indicated that the mother reporting fear of her partner was significantly related to abuse of the child ($P = .003$) but not to abuse of the mother ($P = .658$).

## DISCUSSION

In our study we describe our experience screening for DV in a pediatric practice setting. Several investigators have screened for DV in primary care settings such as the emergency department and family practice, as well as in the internist's and the obstetrician's office.[2,3,15] There is little information on the incidence of DV and the practicality of screening in the pediatric office setting. Wissow et al[16] described screening for DV in a resident continuity clinic and reported an incidence of 40%. It is not clear whether this experience can be generalized to the community practice. McKibben et al[17] reported a 16% incidence of DV in a control group of mothers of nonabused children in a study describing the incidence of DV in mothers of abused children. The incidence of DV in mothers of abused children was 59.4%.[17] McKibben's study was retrospective, however, and may not reflect the incidence when screening is done prospectively.

The AAP recently suggested that all pediatricians incorporate DV screening as part of anticipatory guidance.[10] With the recommendation, it was suggested that pediatricians have in place a protocol in the event DV is uncovered. It is not clear, however, whether pediatricians have the resources, time, and knowledge to screen in the community practice setting. Several studies have shown that practitioners are reluctant to screen because of lack of time, knowledge, and experience.[11–13] A recent study by Wright et al[18] showed <30% of pediatric emergency medicine fellows receive any instruction on DV management. Also, previous studies have shown acceptance of recommendations is not optimal if pediatricians are not convinced of the practicality and necessity of the recommendation.[19,20]

Our data indicate that >30% of women in our practice have experienced violence from a partner. More than half of the cases of DV occurred within 24 months of screening. This was much higher than we

**TABLE 2.** Summary of Women Who Suffered Abuse Within 24 Months of Screening

| Number | Age (Years) | Number of Children | Abuse | Action Kentucky Domestic Violence Team (KDVT) |
|---|---|---|---|---|
| 1 | 19 | 1 | Pushed into a wall when 5 months pregnant. Father out of home. Afraid of partner. | No previous report.<br>Reported to KDVT. |
| 2 | 22 | 1 | While pregnant, pushed, had hair pulled, and hit with bruises. Father out of home. Afraid of partner. | No previous report.<br>Reported to KDVT. |
| 3 | 17 | 1 | Hit in face when 7 months pregnant. Afraid of partner. Father out of home. | No previous report.<br>Reported to KDVT. |
| 4 | 18 | 1 | Punched in abdomen at 2 months pregnant to induce abortion. Father out of home. | No previous report.<br>Reported to KDVT. |
| 5 | 18 | 1 | Hit and bruised at 1 month pregnant. Father out of home. | No previous report.<br>Reported to KDVT. |
| 6 | 19 | 2 | Hit and thrown several times during pregnancy. Bruising. Parents in counseling. | Previously reported.<br>Reported to KDVT. |
| 7 | 24 | 3 | Chained and dragged from back of truck at 6 months pregnant. Father incarcerated. Afraid of partner. Hit children. | Previously reported.<br>Reported to KDVT.<br>Children referred to counseling. |
| 8 | 27 | 2 | Assaulted when 6 months pregnant. Bruising. Hit children. Father incarcerated. | Previously reported.<br>Reported to KDVT. |
| 9 | 26 | 1 | Hit when 3 months pregnant. Father out of home. Has restraining order. Partner out of home. | Previously reported.<br>Reported to KDVT. |
| 10 | 30 | 3 | Hit by partner until 3 months pregnant. Father out of home. Had a restraining order. Afraid of partner. | Previously reported.<br>Reported to KDVT. |
| 11 | 20 | 1 | Choking and stalking by partner. Afraid of partner. Father out of home. Threatened to hurt to child. | No previous report.<br>Reported to KDVT. |
| 12 | 21 | 1 | Hit and choked by partner. Father out of home. | Previously reported.<br>Reported to KDVT. |
| 13 | 25 | 3 | Hit by partner. Partner tried to strangle sister-in-law. Police involved. | Previously reported.<br>Reported to KDVT. |
| 14 | 21 | 1 | Hit by partner. Pulled hair. Father in counseling. Afraid of partner. | Previously reported.<br>Reported to KDVT. |
| 15 | 22 | 1 | Hit by partner. Partner kicked dog and carries gun. Police involved. Father out of home. | Previously reported.<br>Reported to KDVT. |
| 16 | 30 | 1 | Hit by partner. Unreported child abuse. Father out of home. | Previously reported.<br>Reported to KDVT.<br>Child abuse reported. |
| 17 | 25 | 1 | Hit by partner. Bruising. Has restraining order. Father out of home. | Previously reported.<br>Reported to KDVT. |
| 18 | 24 | 2 | Hit by partner. Bruising. Police involved. Father out of home. | Previously reported.<br>Reported to KDVT. |
| 19 | 24 | 2 | Grabbed, pushed and thrown by partner. Currently pregnant by same partner. Father out of home. Has restraining order. | Previously reported.<br>Reported to KDVT. |
| 20 | 35 | 4 | Hit in face by partner. Police involved. Father out of home. Has restraining order. Father out of home. | Previously reported.<br>Reported to KDVT. |
| 21 | 19 | 1 | Threatened mother. Has restraining order. Father out of home. | Previously reported.<br>Reported to KDVT. |
| 22 | 24 | 2 | Hit in face. Bruising (black-eye at office visit). Father incarcerated. Mother not pressing charges. | Previously reported.<br>Reported to KDVT. |
| 23 | 21 | 1 | Grabbed and bruised. Father was arrested and now out of home. | Previously reported.<br>Reported to KDVT. |
| 24 | 21 | 2 | Dragged and suffocated. Father out of home. Has restraining order. | Previously reported.<br>Reported to KDVT. |
| 25 | 25 | 1 | Hitting and bruising by partner. Father incarcerated. Hit child. | Previously reported.<br>Reported to KDVT. |

expected because only 1 case of DV had been reported by the practice in the 4 years preceding this study. Also, the incidence of DV was high in families regardless of their insurance status, suggesting that universal screening be used.

Screening in the obstetric setting has proved to be particularly important because pregnancy has been associated with a higher risk of women being abused and injured.[21,22] It has become the practice of our hospital staff to screen routinely for DV at the time of labor. Many of the obstetricians in our community also screen. Ten of the acutely abused women in our study were injured during their most recent pregnancy. Still, only half of these events were reported before the screen in our office. This finding suggests that screening in the obstetric setting alone may not uncover many DV episodes and that it is critical that DV screening be done by pediatricians. Although the abuser was out of the home in all 10 of these cases, no legal action had been taken in half to protect these women or their children from the partners' return. DV screening may be of particular benefit to this subgroup of women because they can be referred to legal services to try to further protect themselves and their children.

Screening for abuse of the child by the partner also proved to be productive with 5 women describing such abuse. Two of the episodes were unreported previous to the screen and were then reported. Child abuse, as expected, was a marker for a more critical home situ-

ation because 4 out of 5 of these women reported fearing their partner. Although the numbers are too low to interpret, this finding implies that the abused women may be more concerned about the safety of their children than their own safety. Pet violence, however, was only reported in 2 instances and does not seem to be related to fearing the abusive partner.

There are many limitations to this pilot study. The number of women screened was small. Although the incidence of DV was not significantly different in insured families versus families on Medicaid, there may indeed be a significant difference if a larger group of women is screened. Still, our results show that there is merit to screening in families with private insurance. It should also be remembered that our study almost certainly missed many cases of DV, because not all women will report abuse at the time of screening. It is particularly concerning that only 3 women reported DV and were still living with their partner. This finding implies that the group of women at highest risk may be hard to identify and help. Finally, we cannot make any conclusions about long-term outcome of screenings. The purpose of this pilot study was to explore the efficacy of screening for DV in a community pediatric practice setting. We plan to address the longer term outcomes of our screenings and referrals in a large multipractice study. The practices in this study will cover a broad socioeconomic range of clients and the abused women will be tracked during a 3- to 6-month period to determine the outcomes of screening and referral.

We have demonstrated that when women are screened in the community pediatric practice setting they will disclose DV. Also, we were encouraged that there is a subgroup of women, those with young children who have recently separated from their abuser, who may particularly benefit from screening. Based on our experience we believe the recent AAP recommendations on DV screening are justified and can be implemented in the community practice setting. We firmly agree that all pediatricians should be screening for DV.

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